MINISTRY OF HEALTH
DEPARTMENT OF HEALTH FOR SCOTLAND

REPORT

OF THE INTER-DEPARTMENTAL COMMITTEE ON THE

REMUNERATION OF CONSULTANTS AND SPECIALISTS

Presented to Parliament by the Minister of Health and the Secretary of State for Scotland by Command of His Majesty
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INTER-DEPARTMENTAL COMMITTEE ON THE REMUNERATION OF CONSULTANTS AND SPECIALISTS

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NOTE.—SIR HORACE P. HAMILTON, G.C.B. was appointed to the Committee in place of SIR THOMAS GARDINER, G.B.E., K.C.B., who resigned in September, 1947.

The estimated gross cost of the preparation of this Report (including the expenses of the Committee and witnesses) is £472 10s. 1d. of which £88 10s. 0d. represents the estimated cost of printing and publishing this Report.

REPORT OF THE INTER-DEPARTMENTAL COMMITTEE ON THE REMUNERATION OF CONSULTANTS AND SPECIALISTS

To the Rt. Hon. ANEURIN BEVAN, M.P., Minister of Health and the Rt. Hon. ARTHUR WOODBURN, M.P., Secretary of State for Scotland.

SIRS,

We have completed the task for which we were appointed in May, 1947, and have now the honour to submit our report.

Our terms of reference were as follows:—

> " To consider, after obtaining whatever information and evidence we thought fit, what ought to be the range of total professional remuneration of registered medical practitioners engaged in the different branches of consultant or specialist practice in any publicly organised hospital and specialist service; to consider this with due regard to what have been the financial expectations of consultant and specialist practice in the past, to the financial expectations in other branches of medical practice, to the necessary post-graduate training and qualifications required and to the desirability of maintaining the proper social and economic status of specialist practice and its power to attract a suitable type of recruit, having regard to other forms of medical practice; and to make recommendations."

1. *Evidence*

It was brought to our notice that a special committee called the Evidence Committee on the Remuneration of Consultants and Specialists had been set up by the Royal Colleges and the British Medical Association jointly, with the purpose of preparing evidence on behalf of consultants and specialists generally, and we decided to consider the written and oral evidence which this Committee was prepared to submit. The Evidence Committee consulted 23 medical organisations including the Royal Colleges and many specialist associations in the course of its task so as to ensure that the evidence tendered, in so far as it involved expressions of opinion and judgments regarding professional matters, was in accordance with the majority views of specialists and consultants in every branch of Medicine. We anticipated that these various organisations might wish to submit separate evidence in substantiation of any points which concerned them individually and which were not in their opinion adequately covered by the statements prepared on their behalf by the Evidence Committee. We accordingly invited written evidence both from those organisations which were directly represented on the Evidence Committee and also from a large number of associations representative of particular branches of specialist practice whether or not these had already been approached by the Evidence Committee. We also issued a general invitation by means of a press notice to anyone disposed to furnish us with any relevant information. A list of the organisations and individuals from whom written statements have been received, and of the witnesses examined orally, is contained in Appendix I.

The ready response we received to our invitation both in the forms of written evidence and of offers to tender oral evidence was a great help in our investigation and we should like to take this opportunity of expressing our indebtedness and cordial thanks to all those who assisted us in this way. In view of the large measure of agreement found in the evidence received from all sections of the profession and the exhaustive character of the information furnished by the Evidence Committee, we found it

necessary to request additional oral evidence from the Evidence Committee and the Royal College of Physicians only. We completed our task after holding sixteen meetings.

We were instructed in our remit to have due regard to what had been the normal financial expectations of consultant and specialist practice in the past. We considered very carefully at the outset to what extent the incomes of consultants in the publicly organised service of the future should be related to past incomes which had been derived mainly from private practice, and we decided that in accordance with our remit we were bound to have regard to past remuneration from all sources in judging what effect our recommendations were likely to have upon the recruitment of medical practitioners to the consultant ranks. The necessary statistical information was obtained for us by the Evidence Committee, which, under the guidance of Professor A. Bradford Hill, conducted an inquiry in the form of a questionnaire to consultants and specialists. A tabular statement prepared by Professor Bradford Hill containing some of the results of this inquiry forms an Appendix to this report (Appendix II). We have also had regard to salary scales already in force for salaried members of the medical profession in organised medical services.

2. 1939 *Values*

At an early stage in our deliberations it appeared to us that social and economic conditions were not yet sufficiently stable to justify the basing of our recommendations on evidence relating to remuneration in the post-war period, and the Evidence Committee was accordingly asked to obtain information of incomes earned in the year 1938-39. With this evidence before us, and realising that we were not qualified as a Committee to form an opinion on what adjustment of immediately pre-war incomes was necessary to produce corresponding incomes to-day, we decided that the best course for us to pursue was to frame our recommendations in terms of the 1939 value of money. This conclusion has not prevented us from taking into account post-war conditions in so far as they affect the development of Medicine, particularly in regard to developments in the newer specialties and to modifications in the organisation of hospital services. We leave to others the problem of the necessary adjustments to present-day values of money, but we desire to emphasise as strongly as possible that such adjustments should have direct regard not only to estimates of the change in the value of money but to the increases which have in fact taken place since 1939 in incomes both in the medical and in other professions. In our judgment it is only if corresponding changes are made in the incomes of consultants and specialists that the recruitment and status of the various branches of specialist practice will be maintained.

3. *Interpretation of Remit: Training Period*

We were at first disposed to interpret the terms " consultant " and " specialist " in our remit as referring to those medical practitioners who after completion of a series of hospital appointments and attainment of a higher qualification are appointed to membership of the staff of a hospital. After consideration of the evidence submitted to us, however, we concluded that the remuneration appropriate to specialists of staff status was to such an extent dependent upon remuneration and conditions of service during the period of specialist training which must precede appointment to the staff that it was advisable for us to give a clear indication of what in our view would constitute adequate remuneration during this training period. We therefore ultimately

decided to interpret the term " specialist " in our remit so as to include the whole group of practitioners who after registration and completion of junior house appointments are appointed to hospital posts in training for a special branch of Medicine.

4. *Past Conditions: Career Picture*

It may be convenient to include a description of the career of a specialist from the time when he is placed on the medical register. Until now, medical students have normally qualified at the age of 23 or 24 after some five or six years of undergraduate study. Immediately after qualification the practitioner may hold one or more house appointments, and this part of the post-graduate training, which normally occupies a period of one year, is an essential step for those who aspire to consultant status. During this period, or during the tenure shortly afterwards of other junior hospital posts for which he becomes eligible, the intending specialist undertakes intensive academic study with a view to securing a higher qualification in medicine or surgery and also with the aim of obtaining, at approximately four years from registration, appointment to the most senior training posts, for which a higher qualification is normally a requisite. These posts are differently named in different hospitals but are more commonly known as registrar, senior registrar, first assistant or chief assistant. A practitioner holding one of these posts has no direct charge of patients but is responsible to his medical or surgical chief for the care of patients during the latter's absence. As he gains experience he is given more and more responsibility, so that, for instance, a surgeon in the latter part of his registrarship undertakes major operations, and such supervision as exists at this stage is really in the nature of assessment of his potentialities as a specialist. On completion of his tenure of this post the practitioner is ready for appointment to the staff of a hospital, when he will be recognised as having full specialist status.

We were particularly impressed by the drastic selection to which specialists in the early part of their career are subjected, both for appointment to the posts through which they are required to pass and for the conferment of academic awards and distinctions which may considerably affect their career. After graduation there is keen competition for suitable house appointments, many of those who qualify being eliminated at this stage; there is further competition for appointment to each of the training posts subsequently held; and finally, from the comparatively small number of registrars, etc., selection is made for appointment to a hospital staff. The distinctions for which intending specialists compete include scholarships awarded on entry to medical schools, awards and medals attached to annual class examinations during undergraduate training, post-graduate scholarships, and finally the higher qualification normally competed for prior to registrarship and obtained by approximately one-sixth of the profession.

In most hospitals the initial staff appointment is that of assistant physician, assistant surgeon etc. When the term " assistant " is used it does not necessarily imply that the holder of such an appointment is subordinate to the physician or surgeon. He may have fewer hospital beds in his charge than the physician or surgeon but he assumes complete responsibility for the patients admitted to his care.

5. *Past Conditions: Finance*

We appreciated that the statistical information reproduced in Appendix II is not by itself sufficient to reveal fully the financial conditions which have

obtained in specialist practice. For example, the inquiry undertaken by the Evidence Committee did not attempt to show what has been the level of remuneration during the period of training, and for this we have relied upon other evidence. There are also various factors not apparent from examination of the statistics which have affected incomes earned in the past by consultants engaged partly in hospital and partly in private practice. It was, for instance, emphasised in evidence that in the past possession of private means often enabled a man to continue as a specialist in spite of a limited private practice, and that lower levels of taxation in the pre-war period enabled some specialists to accumulate sufficient savings to allow them to cut down their practice in the later years of their active life. In interpreting the statistics we have borne such considerations as these in mind.

It was strongly stressed in evidence that the remuneration attached in the past to the junior hospital posts held immediately after completion of house appointments had borne little relation to the progressively increasing responsibilities of these posts, to the standard of living required of the practitioner, and to the need for freedom from financial worry during this extremely important part of his career. We were told that many potential specialists are diverted into general practice at an age when marriage is contemplated and the emoluments attached to training posts are not sufficient to meet new responsibilities. These difficulties are progressively accentuated throughout the training period, and when the registrar posts are reached the practitioner is normally compelled to rely upon his private financial resources or to undertake much outside work such as coaching to enable him to meet his financial commitments. We were informed that hospital registrars before the war received £300 to £400 or less, even in non-resident posts.

In the past no substantial income has been derived directly from a staff appointment in a voluntary hospital, though a successful private practice has normally accrued from the possession of such an appointment. We were, however, informed that a fully qualified specialist has often had to wait several years before a suitable hospital vacancy has occurred. Moreover, on obtaining a staff appointment, whatever his age, the specialist has had to face the risks, hardships and uncertainties involved in the effort to build up a private practice. At this stage, his earnings from private practice have seldom met his overhead expenses and here again he has often been dependent to a considerable extent upon private means or outside work.

6. *Future conditions*

In assessing the appropriate remuneration for the budding specialists of the future we have had regard to the view of the profession, endorsed by the Goodenough Committee and the General Medical Council, that the holding of pre-registration house appointments should be compulsory. We have also had regard to the long period of training required in some of the more specialised branches of Medicine. We were informed that criteria for recognition of specialist status involving a minimum period of five years of training after medical qualification, or eleven years professional training in all, have been proposed by many groups of consultants and specialists including general physicians, surgeons, obstetricians and gynaecologists, cardiologists, dermatologists, neurologists, paediatricians, psychiatrists, oto-rhino-laryngologists, anaesthetists, clinical pathologists and radiologists.

In considering what the remuneration of consultants of staff status should be we have assumed that there will be reasonable security of tenure comparable to that at present enjoyed by the staffs of voluntary hospitals. We have

also borne in mind that in a public service the consultant's remuneration will be maintained until the age of retirement is reached.

7. Equality of Status between the Different Branches of Specialist Practice

We were instructed in our remit to consider what ought to be the range of total professional remuneration of medical practitioners engaged in the different branches of specialist practice, and we discussed at some length whether different ranges of remuneration would be appropriate for different branches. We concluded that it would be a mistake to base future remuneration on the differences between various branches which were disclosed by the statistical inquiry. We are of opinion not only that those branches of Medicine which were at a marked disadvantage in 1939 were underpaid, but that many have developed to such an extent that the remuneration obtainable in 1939 gives no indication of the present prospects which they offer in conditions of private practice. We realised also that a determining factor might be whether different retiring ages were appropriate to different branches of Medicine, but we decided to accept the view of the Evidence Committee that there should be a uniform retiring age of 65 for all specialists regardless of the branch of Medicine in which they practise. We eventually reached the conclusion that in view of the standards of qualification and the length of training now proposed for the various special branches it would be unfair to recommend that any specialty should be relegated to a subordinate place in Medicine by denying its members access to the highest levels of remuneration. We are certain that unless all specialists in whatever branch of Medicine they practise have an opportunity of reaching the highest levels of remuneration the ancillary specialties, however important, will find it difficult to attract sufficient recruits of suitable calibre. The principle upon which we decided to base our recommendations was that all varieties of specialists should be remunerated within the same range of incomes, the place of an individual within this range being dependent upon his responsibilities, experience and skill. Thus the highest remuneration would be open to specialists in all fields although the proportion attaining that remuneration might be less in some fields than in others and might vary with the increasing importance of this or that branch of Medicine.

We would make, however, a subsidiary recommendation which while formally applicable to specialists in every field would in practice apply in the main in some fields rather than in others. Precisely because the need for domiciliary visits will not be uniformly distributed as between different fields and because of the very considerable additional burden which such visits involve we consider that some additional remuneration should accrue in respect of these.

8. Equality of Status between Hospitals

We have had regard also to the view of the profession and the intention underlying the National Health Service Act that in the hospital system of the future there should be a more uniform level of hospital efficiency throughout the country, a better distribution of specialists, and permeation throughout the hospital service of each region of the influence of the university centre. These objects can be achieved only by increasing the mobility of specialists throughout the service and facilitating the interchange of staffs between teaching and non-teaching hospitals. The hospital system of the future is being organised in such a way that there will be in each region both teaching hospitals and area hospital centres. The many small independent hospitals, both general and special, which are at present scattered throughout the

country will be linked in these area hospital centres. From the viewpoint of the patients, it is desirable that modern advances in Medicine should be made available in areas outside the radius of the present teaching centres. In these circumstances it is obviously important that the status of the area hospital centre should be in no way inferior to that of the teaching hospital, and that both should be able to attract specialists of the highest calibre. We are therefore of opinion that the same range of remuneration for clinical work should apply to specialists in both teaching and non-teaching hospitals.

PROPOSALS

9. *Remuneration of Potential Specialists*

We now turned to our first major problem: that of determining the proper remuneration for potential specialists after completing one year's house appointments and before obtaining a post on the staff of a hospital.

In framing proposals on this subject we have had prominently in mind the evidence about past conditions during the training period to which we call attention in section 5 above. We are of opinion that in a public service intending specialists who do not possess private means should not be called upon to pass through a stage of comparative penury and hardship. Nor should they be tempted to spend too much time in supplementing their income from other sources, such as coaching, when they could be more suitably occupied in their professional studies. Having regard to the career picture which we have drawn from the evidence, we consider that the medical practitioner, between the completion of his first house appointment and appointment to the staff, should be paid a salary which is not merely in the nature of a training grant but which reflects both the growth in his skill and the increasing responsibility of his work.

We have referred already to the lengthening of the period of training which is likely to be involved in the future organisation of medical studies, and, in particular, we considered sympathetically the position of practitioners undergoing specialist training in those branches of Medicine which already demand an exceptionally long period of training, such as neuro-surgery and thoracic surgery. Moreover, whilst realising the inadvisability of making it easier for individuals to prolong indefinitely their tenure of posts below those of full staff status, we think it necessary to safeguard the position of the fully trained registrar who is compelled to wait a limited time for a vacant staff appointment. At the same time, we wish to emphasise that in our opinion all possible steps should be taken by encouraging the interchange of specialists between hospitals to minimise and equalise this unavoidable waiting period.

We have thought it necessary for the purpose of our remit to relate proposed salaries during the training period to the various posts which are successively held prior to appointment to the staff. We realise that the nomenclature of these posts differs widely in various parts of the country, and we have thought it best to define them by reference to the number of years after registration at which they are normally held. These appointments fall thus into three well-defined grades:—

(*a*) Grade III: posts obtained normally not less than one year after registration and held normally for one year only (e.g., senior house officer, resident medical officer, etc.);

(*b*) Grade II: posts obtained normally not less than two years after registration and held normally for two years at the ages of 26 and 27 (e.g., assistant, junior registrar, etc.);

(*c*) Grade I: posts obtained normally not less than four years after registration and held normally for three years at the ages of 28, 29 and 30 (e.g., first assistant, chief assistant, senior registrar, etc.).

These definitions avoid difficulties of nomenclature and are sufficiently flexible to admit of general application; a longer or shorter time than that stated in the definitions might be spent in any of these grades. Nevertheless, by indicating a general standard related primarily to the length of time after registration, the definitions have regard to age, which at this stage of the specialist's career is a most important factor.

In our view, the appropriate salaries for these grades are as follows:—

Grade III: a fixed salary of £600.

Grade II: £700 rising by one annual increment of £100 to £800.

Grade I: £900 rising by two annual increments of £100 to £1,100.

Where tenure of a post in Grade I continues beyond three years, the salary should rise by a further increment to £1,200 in the fourth year and remain at this figure in any further years.

In recommending these salaries we have in mind non-resident posts; where residential emoluments are received, an appropriate sum would require to be deducted from the salary.

10. *Range and Differentiation for Full Consultants*

The second major problem to which we addressed ourselves was to determine the total range of remuneration for consultants of full staff status, and to secure within this range sufficient differentiation of incomes to provide the necessary incentives, consistently with the two principles referred to above—equality of status between the various branches of specialist practice, and equality of status between teaching and non-teaching hospitals.

11. *The Lower Limit of the Range*

In discussing what should be the lower limit of the range of remuneration for staff specialists, we took into account the effect which this figure will inevitably have upon recruitment. The adequacy of the remuneration for the first few years will more than any other factor determine the attitude of the practitioner who is considering whether or not to embark upon the arduous path of specialisation. As regards starting salary we agreed to recommend that on appointment to the hospital staff a specialist should receive £1,500 per annum, provided he has attained the age of 32, which we think will be a normal age.

In the exceptional case where a specialist is appointed to a hospital staff at the age of 30 or below we recommend that the starting salary should be £1,250, rising by annual increments of £125. It would follow that if a man were appointed at the age of 31, he would receive £1,375 on appointment, and £1,500 at 32. It may often happen that a specialist will not attain a staff appointment for some years after the age of 32. In that event we recommend that the hospital authorities should have freedom to vary the initial salary of £1,500 by allowing up to four special increments of £125 each in respect of age, special experience and qualifications.

12. *The Maximum Figure of Remuneration*

The statistical tables prepared by Professor Bradford Hill show that it has been possible for a small proportion of practitioners in the past to obtain

incomes of a very high order. Bearing in mind that the salaries we have recommended above would remove the hardships at present experienced during the period of training; that in a public service the specialist ought not at any stage of his career to require to supplement his earnings by private means; that his remuneration will be maintained at a consistent level until the age of retirement is reached; and that throughout his career the specialist will enjoy financial security in marked contrast with the uncertainties of private practice, we concluded that some reduction was justifiable not only in the ceiling figure of the incomes attainable in the past, but also in the proportion of consultants attaining to the highest levels of remuneration. On the other hand, we would emphasise that if the best possible recruits are to be attracted to specialist practice, there must remain for a significant minority the opportunity to earn incomes comparable with the highest which can be earned in other professions. There is a further point to which we attach great importance. We are convinced that the remuneration offered to specialists of exceptional ability must be sufficient not only to attract the most able specialists of this country to the public service, but to maintain the position of British Medicine in a competitive market which includes the Dominions and the United States of America.

After consideration of these factors we concluded that specialists of the highest eminence should be able, in the public service, to aspire to a remuneration of the order of £5,000 for clinical work.

13. *Differentiation within the range*

We turn to the question of what should be the spread of incomes within the range of £1,500 to £5,000, and of how such a spread could be realised. We are directly concerned only with what remuneration specialists ought to receive, not with the method of their payment. On the other hand, the problems involved in determining the former cannot be wholly separated from the latter. We are satisfied that there is a far greater diversity of ability and effort among specialists than admits of remuneration by some simple scale applicable to all. If the recruitment and status of specialist practice are to be maintained, specialists must be able to feel that more than ordinary ability and effort receive an adequate reward. Moreover, a reward which would be appropriate when these exist would be extravagant when they do not. In consequence we are clear that any satisfactory system of remuneration must involve differentiation dependent on professional distinction.

Acceptance of this principle without qualification would imply that age or length of service should not be a factor which determines the remuneration of a specialist. On consideration, however, we were agreed that after his appointment to the staff of a hospital, the specialist, although his training is complete and he undertakes sole personal responsibility for the patients under his charge, continues for a number of years to gain an increasing variety and width of practical clinical experience which progressively enhances the value of his work. It seems to us, therefore, that, whilst age or length of service should not at any time during his tenure of a staff appointment be the sole factor determining remuneration, there should be, during the earlier years, in addition to some means of recognising and rewarding exceptional individual merit, a uniform scale of annual increases in remuneration applicable to all specialists alike.

We therefore recommend that the initial salary paid to the specialist on his appointment to the staff should be augmented by an additional £125 after each year of service, until a maximum basic salary of £2,500 has been reached. We consider that beyond this point, which if staff status is achieved at the

age of 32 would be at the age of 40, an automatic incremental basic scale of remuneration would be inappropriate, and remuneration should cease to depend in any way at all upon the length of service of the specialist.

It remained for us to consider in what way a satisfactory spread of incomes could be obtained in the higher age range, and what should be the method of differentiation between specialists to achieve this spread of incomes and to ensure that in the lower age range also outstanding ability should be rewarded by remuneration in excess of the basic incremental scale we have already envisaged. Although as we have said we are not directly concerned with methods of payment, we are clear that if the profession is to be satisfied and recruitment maintained it is essential that a method of differentiation involving the selection of individuals for exceptional reward in respect of outstanding professional ability must command the confidence of the profession. We have thought it right therefore to indicate the kind of machinery for achieving differentiation which appears to us to be required.

We recommend that the task of selecting individual specialists whose outstanding distinction merits additional reward should be in the hands of a predominantly professional body, and that this body should be as detached as possible from individual hospitals and particular localities. In our view it will be advisable to set up new and special machinery to undertake this task, and we are satisfied that the most suitable machinery for the purpose would be a national committee consisting in the main of eminent members of the profession who from their own knowledge or otherwise would be able to reach an authoritative opinion on the comparative merits of candidates. We recommend that the constitution of this committee should be discussed with the Royal Colleges and the Scottish Royal Corporations, and that the professional members should be nominated by these Colleges and Corporations. We suggest that the committee should also include a representative of the Universities and a representative of the Medical Research Council.

In our opinion this Committee should be empowered to recognise special contributions to Medicine in the field of research or otherwise, exceptional ability, or any outstanding professional work (other than administrative) by the conferment on selected individuals of distinction awards in three grades. The first and highest distinction should carry with it an award of £2,500 per annum by way of addition to the basic salary, the second an award of £1,500 per annum, and the third an award of £500 per annum. All specialists of staff status who are engaged whole-time in the publicly organised service should be eligible for these distinctions and for the monetary awards attaching to them. Specialists of like status who are engaged part-time in that service should equally be eligible for these distinctions and for the appropriate proportion of the corresponding monetary awards.

We consider that in order to preserve a proper distribution of incomes throughout the entire range of remuneration the number of distinction awards conferred should be a fixed percentage of the total number of consultants eligible, and we recommend that 4 per cent. of all consultants eligible should be selected for conferment of the first distinction, 10 per cent. for conferment of the second distinction, and 20 per cent. for conferment of the third distinction. This will have the effect that approximately one third of all specialists will receive more than the basic salary of £2,500.

It appears to us that this method of securing differentiation would not only maintain a proper proportion of the higher incomes, but would have the advantages of providing sufficient incentives to stimulate effort and encourage initiative; of holding out opportunities of higher reward to all specialists alike,

in whatever branch of Medicine they practise; and, by throwing these awards open to specialists in all hospitals, of making it possible to maintain equality of status between hospitals and encourage a proper distribution of specialists. With this latter object in mind we would emphasise strongly that, whilst it would in our view be impracticable to distribute these distinctions on the basis of a specified quota for each hospital region, they should not be allowed to gravitate towards a few large teaching hospital centres; and we wish to stress that, in making awards as between those who on other grounds appear to have equal claims, regard should be had to the desirability of spreading such awards over the country, as well as over different branches of specialist practice. In recommending the above percentages we have had in mind among other considerations the importance of making possible such a distribution.

14. *Teaching*

We did not regard it as within our terms of reference to make recommendations regarding the remuneration of specialists holding whole-time teaching appointments. We have, however, given thought to the general question whether the specialist undertaking teaching duties should receive additional remuneration in respect of those duties. We have stressed the importance of avoiding two different standards of specialist service in teaching and non-teaching hospitals, and this can only be done if equivalent clinical work at either type of hospital attracts equal remuneration. We desire, however, to place on record that we do not consider that equality of status between hospitals would be prejudiced if a combination of clinical work and teaching, undergraduate or post-graduate, professorial or non-professorial, attracted higher total remuneration. We are doubtful, indeed, whether it will be possible to secure the best men for teaching unless they receive higher total remuneration. We have no doubt that teaching is an additional burden on the specialist, and calls for special aptitude and skill. In the future, as post-graduate teaching is extended, most hospitals will undertake a share of this work, and the proportion of specialists who would be eligible for additional emoluments for teaching would be correspondingly increased. We envisage, of course, that clinical teaching officers will be eligible for the special distinction awards referred to in section 13.

15. *Part-Time*

The above proposals regarding basic salaries relate to consultants who are engaged whole-time in a publicly organised service. We next considered the position of specialists engaged part-time in that service. In our view the responsibilities and commitments of a part-time appointment cannot be measured, in relationship to those of a whole-time appointment, simply by comparing the total working hours of the part-time officer with the total working hours of his full-time colleague. The specialist who holds a part-time hospital appointment has a continuous responsibility for the patients in his charge, which must extend beyond the limits of the time he contracts to serve; further, he will be expected to take his share in the committee work of the hospital, and this must encroach upon time which would otherwise be spent in private practice. In assessing the remuneration which shall attach to part-time appointments such factors must be taken into account.

On the assumption that a specialist in whole-time service would undertake a working week of 11 half-days we suggest that the part-time specialist should be required to devote to the service a specified number of half-days per week. On this basis of computation we recommend that where x represents

the number of half-days per week which the part-time specialist is required to work, his basic remuneration should be $\frac{x}{11}$ of the basic remuneration of whole-time specialists of like status, plus one-quarter of $\frac{x}{11}$ or one-quarter of $\frac{11-x}{11}$ of that remuneration, whichever be less.*

We envisage also that special circumstances might arise where a rate of remuneration for part-time appointments higher than that recommended above should be applied, on a personal and in some cases temporary basis, to individual specialists. For example, acceptance of a part-time contract might depend upon uncertain prospects of building up or maintaining a private practice in a particular locality. We recommend that hospital authorities should have freedom to offer at least temporarily a higher rate of remuneration for part-time appointments where such special circumstances exist.

16. *Expenses, Superannuation and Holidays*

There are three further points to which we wish to refer in order to avoid any possibility of misunderstanding.

Firstly, throughout our proceedings we have assumed that specialists engaged either whole-time or part-time in a publicly organised service will be paid any sums which represent expenses necessarily and reasonably incurred in the course of their work, and that these sums will be in addition to the salaries recommended. The Evidence Committee has brought to our notice a number of items of expense which must be met if the specialist is to perform his duties efficiently. These include car expenses; expenses of travel apart from the use of a car; the cost of renewal of instruments and other equipment; the cost of books and journals, preparation of scientific papers, and subscriptions to professional societies; printing, stationery, postage and telephone costs; expenses of attendance at national and international professional meetings; and the expenses of visiting hospitals and clinics at home and abroad, and entertaining visiting colleagues.

The expenses might be refunded after they have been incurred, or alternatively an appropriate allowance for expenses might be attached to the various posts held by specialists and consultants. If the latter course were adopted it would have to be realised that certain expenses would arise which had not been foreseen when the allowance was fixed, e.g., attendance at an international conference, and additional provision would have to be made in such cases.

It is presumed that the Inland Revenue authorities would be prepared to consider favourably as legitimate allowances for Income Tax purposes any items of expense which had been approved by a public hospital authority.

Secondly, in the above discussions and in the recommendations which we have made, we have assumed that, as in private practice in the past, specialists will have themselves to provide by insurance against death and old age: in so far as this ceases to be the case, adjustment would be necessary.

Thirdly, in our discussions and the recommendations we have made we have assumed that in a publicly organised service the specialist would be

* The effect of this arrangement may be illustrated as follows: If a specialist engaged part-time in the service contracted to serve 4 half-days per week his basic remuneration would be £1,136, and if he contracted to serve 7 half-days per week his basic remuneration would be £1,818. These figures are on the assumption that if engaged whole-time he would be receiving £2,500.

entitled to certain definite holidays, and would not be financially liable for providing a deputy. We would add that, in our view, apart from normal holidays, extended leave will in the interests of the service be necessary on occasion for study or research.

17. *Summary of Recommendations and Conclusions*

Our recommendations regarding the remuneration of consultants and specialists in a publicly organised hospital and specialist service are, therefore, as follows:—

(1) Medical practitioners in training for the special branches of Medicine should receive

(*a*) a fixed salary of £600 per annum during their tenure of those hospital posts which are normally obtained not less than one year after registration and are normally held for one year only (e.g., senior house officer, resident medical officer, etc.);

(*b*) a salary of £700 rising by one annual increment of £100 to £800 per annum during their tenure of those hospital posts which are normally obtained not less than two years after registration and are normally held for two years (e.g., assistant, junior registrar, etc.);

(*c*) a salary of £900 rising by two annual increments of £100 to £1,100 per annum during their tenure of those hospital posts which are normally obtained not less than four years after registration and are normally held for three years (e.g., first assistant, chief assistant, senior registrar, etc.). If such a post is held for more than three years the salary should rise by one further increment of £100 to £1,200 in the fourth year, and remain at that figure in any further years.

Note.—These recommendations relate to non-resident posts.

(2) (*a*) A specialist appointed to the staff of a hospital at the age of 32 should receive a starting salary of £1,500 per annum.

(*b*) A specialist appointed to the staff of a hospital at the age of 30 or below should receive a starting salary of £1,250 per annum. A specialist appointed at the age of 31 should receive a starting salary of £1,375 per annum.

(*c*) In the case of specialists appointed after the age of 32 hospital authorities should have freedom to vary the starting salary of £1,500 by allowing up to four special increments of £125 each in respect of age, special experience and qualifications.

(3) The initial salary of a specialist on the staff of a hospital should be augmented by an additional £125 after each year of service, until a salary of £2,500 has been reached.

(4) A national committee should be set up, with the task of selecting individual specialists whose outstanding distinction merits a higher reward than that which the above recommendations would provide. The constitution of this committee, which should be predominantly professional, should be discussed with the Royal Colleges and the Scottish Royal Corporations. The professional members should be nominated by these Colleges and Corporations.

(5) This committee should confer distinction awards, in three grades, on selected specialists, in recognition of special contributions to Medicine, exceptional ability, or outstanding professional work (other than administrative).

(*a*) Distinction in the first and highest grade should carry with it an award of £2,500 per annum by way of addition to the salary recommended above; distinction in the second grade an award of £1,500 per annum; and distinction in the third grade an award of £500 per annum.

All specialists of staff status should be eligible for these distinction awards. A specialist engaged part-time in the service on whom a distinction award is conferred should receive the appropriate proportion of the corresponding monetary award.

(*b*) Four per cent. of all specialists eligible should be awarded the first distinction; 10 per cent. should be awarded the second distinction; and 20 per cent. should be awarded the third distinction.

Note.—This would have the effect that approximately one-third of all specialists would receive remuneration in excess of £2,500.

(6) Specialists who undertake domiciliary visits should receive additional remuneration for this work.

(7) (*a*) Where x represents the number of half-days per week which a part-time specialist is required to work, his basic remuneration should be $\frac{x}{11}$ of the basic remuneration of whole-time specialists of like status, plus one-quarter of $\frac{x}{11}$ or one-quarter of $\frac{11-x}{11}$ of that remuneration, whichever be less.

(*b*) Hospital authorities should have freedom in special circumstances to offer, at least temporarily, a higher rate of remuneration for part-time appointments than that recommended above.

Note.—We have assumed

(i) that a specialist in whole-time service undertakes a working week of 11 half-days;

(ii) that a specialist engaged part-time in the service is required to serve a specified number of half-days per week.

(8) All specialists engaged either whole-time or part-time in the service should be paid, in addition to the remuneration recommended above, any sums which represent expenses necessarily and reasonably incurred in the course of their work.

(9) All specialists engaged in the service should be entitled to definite holidays, and to extended leave when necessary for study or research, without being financially liable for providing a deputy.

(10) It is not for us to make recommendations as to the amounts which should be paid for teaching, but we place on record our belief that in order to secure the right men it will be necessary for clinical specialists engaged in teaching, whether undergraduate or post-graduate, to receive increased total remuneration.

In conclusion we wish to record our appreciation of the work of our Joint Secretaries, Mr. T. B. Williamson, of the Ministry of Health, and Dr. D. P. Stevenson of the British Medical Association.

We have the honour to be, Sirs,
Your obedient Servants,

(*Signed*) WILL SPENS (*Chairman.*)
C. R. DALE,
H. P. HAMILTON,
THOMAS LISTER,
ELIZABETH LOOKER,
D. MURRAY LYON,
MORAN,
LESLIE E. PEPPIATT,
HARRY PLATT,
S. COCHRANE SHANKS,
J. R. H. TURTON.

T. B. WILLIAMSON,
D. P. STEVENSON, } *Joint Secretaries.*

19th May, 1948.

APPENDIX I

LIST OF BODIES AND PERSONS WHO SUBMITTED EVIDENCE TO THE COMMITTEE

1. Written and Oral Evidence

Organisation	*Witnesses*
Evidence Committee (*see section 1 above*).	Sir Alfred Webb-Johnson, Bt., K.C.V.O., C.B.E., D.S.O., T.D., P.R.C.S. (*Chairman*)
	Dr. C. B. S. Fuller, M.C., M.D., M.R.C.P.
	Dr. Charles Hill, M.D.
	Lord Horder, G.C.V.O., M.D., F.R.C.P.
	Dr. H. Joules, M.D., F.R.C.P.
	Dr. H. E. A. Boldero, D.M., F.R.C.P. Dr. A. Macrae, M.A., M.B., Ch.B. } (*Secretaries*)
	Prof. A. Bradford Hill, D.Sc., Ph.D. (*Statistician*)
Royal College of Physicians ...	Prof. W. G. Barnard, F.R.C.P.
	Dr. H. E. A. Boldero, D.M., F.R.C.P.

2. Written Evidence only

Association of Anaesthetists of Great Britain and Ireland
Association of Clinical Pathologists
Association of Municipal Specialists
British Association of Physical Medicine
British Association of Urological Surgeons
British Hospitals Association
British Orthopaedic Association
British Paediatric Association
Faculty of Radiologists
Medical Society for the Study of Venereal Diseases
Middlesex County Medical Society
Middlesex Tuberculosis Association
Royal Medico-Psychological Association
Society of British Neurological Surgeons
Society of Thoracic Surgeons of Great Britain and Ireland
University Grants Committee
The Town Clerks of Birmingham, Glasgow and Manchester, the Clerk of the County Council of Middlesex and the Clerk of the London County Council.
Dr. E. A. Haslam Fox, M.B., Ch.B., D.P.M.
Dr. J. F. Heggie, M.B, Ch.B.
Dr. W. L. Munro, B.Sc., M.B.
Dr. A. W. Purdie, M.B., Ch.B., F.R.F.P.S., M.R.C.O.G.

APPENDIX II

THE EVIDENCE COMMITTEE'S INQUIRY INTO THE REMUNERATION OF SPECIALISTS AND CONSULTANTS IN THE YEAR 1938-39

Tables and Explanatory Notes based upon the Report made to the Evidence Committee by Professor A. Bradford Hill, D.Sc., Ph.D.

The object of this inquiry was to obtain factual information on the professional incomes of medically qualified men and women engaged in the year before the war (1938-39) exclusively or predominantly in consultant or specialist practice.

A primary difficulty of the inquiry lay in the entire absence of any list of all persons engaged in such forms of medical practice. The Evidence Committee, therefore, from information furnished by all voluntary hospitals and local authorities in England, Scotland and Wales, compiled a list of all those practitioners who, during 1938-39, were on the part-time visiting staffs of local authority hospitals or of voluntary hospitals with "selected" as distinguished from "open" staffs*. It was known that some large proportion of these persons would not, in fact, be consultants or specialists but predominantly in general medical practice. As, however, there was no way of centrally identifying these two groups, a form was sent to every person on the list thus compiled (excluding, necessarily, those who had died since 1938-39). On this form the recipient was asked to declare (*a*) that he or she was *not* engaged predominantly or exclusively in consultant or specialist practice in 1938-39 and was, therefore, not relevant to the inquiry, or (*b*) that he or she *was* predominantly or exclusively in consultant or specialist practice; in all these cases a return of the 1938-39 income was requested.

By these means an attempt was made to identify and obtain income figures from *all* those who were in consultant or specialist practice in 1938-39 and were still alive in 1947 (whether still active or retired).

To ensure the greatest possible degree of success in the inquiry the income return was made anonymously, a signed statement that it had been made being sent at the same time to the Evidence Committee. It was, however, foreseen that, although secrecy was thus ensured, a hundred per cent. response would not be obtained and that those who chose to reply might not form a representative cross-section of the whole group from which returns were required. As a check upon the presence (or absence) of bias in the returns received a special device was incorporated in the inquiry. Without in any way departing from the principle of absolute secrecy, every tenth form sent out was specially marked, so that a small group of the returns could be identified (but never an individual). It was hoped, through persistent applications, that a reply could be obtained from the *whole* of this smaller sub-group. By comparing the distribution of incomes revealed by it, and their average, with the corresponding figures given by the large but incomplete total of returns, any serious bias in the latter, its degree and its direction, upwards or downwards, would be detected.

The device was not wholly successful since returns from the whole of the sub-group were not obtained. It did, however, allow the following conclusions to be reached:—

(*a*) it is highly probable that the required income returns were obtained from slightly less than three-quarters of all consultants and specialists in practice in 1938-39 and surviving in 1947; this is a high rate of return for such an inquiry;

(*b*) the average net income of the proportion making the required return might, in the age groups under 60, be, at the most, 10 to 15 per cent. too high, i.e., in comparison with the average figures that a 100 per cent. response might have given. There is little doubt that the real margin of error was appreciably less than this.

Apart from this question of a possible bias in the returns received, and the attempt made to measure it, some emphasis must be laid upon the fact that it was impossible to obtain returns for those who were in practice in 1938-39 but had since died. Their absence must certainly distort the picture of the income distributions at all ages put together, since the older men will be missing more often than the younger, i.e., those who were earning higher average incomes in the prime of life or already beginning to earn lower average incomes in old age. For this reason the picture presented at all ages combined should be regarded with considerable caution. Taking the age groups separately it may reasonably be concluded that up to age 50 the absence of returns for the dead is very unlikely to affect the figures substantially, that at ages 50-59 the position is more doubtful while at ages 60 and above the figures for survivors only might well be seriously at fault. It was also found, from the sub-group mentioned above, that at these advanced ages refusal of the survivors to make the required income return reached its maximum rate. This reinforces the case for regarding the figures for old age as of very doubtful value. Reluctance to make the required return was at its lowest rate in the ages of main importance, namely 35-49.

---

* An "open" staff is one to which all local practitioners are appointed solely by virtue of their being in practice in the neighbourhood.

The income return requested was for the one year 1938-39, as returned by the specialist or consultant to the Inspector of Taxes (the actual financial year for medical men and women is a little variable). Particulars were required of gross earnings, professional expenses and net incomes, together with details of the practitioner's qualifications, nature of specialty, etc. The figures extracted from the original tables and here reproduced relate only to the *net incomes of persons exclusively engaged in consultant or specialist practice in* 1938-39 and allocated to the type of specialty in which they stated they were engaged (when more than one branch of practice was mentioned the return was tabulated against the more specialized, e.g., " surgery, mainly E.N.T." would be allocated to the E.N.T. group; " general medicine and psychiatry " to psychiatry; " surgery and gynaecology " to gynaecology. " Medicine " includes such specialties as cardiology, paediatrics, and neurology and " surgery " includes urology). Persons who were absent from their practice in 1938-39 by prolonged sickness (3-4 months or more) were excluded from the returns.

The mean, median and quartile incomes shown in the tables that follow were calculated from the income returns grouped in one-hundred pound intervals and not from the broader classifications used in the tables.

TABLE 1

NET INCOMES. ALL AREAS COMBINED—MEN

Income £000's	Surgery	Gynae-cology	E.N.T.	Ophthal-mology	Ortho-paedics	Medicine	Psychi-atry	Anaes-thetics	Radio-logy	Derma-tology	Patho-logy	Total	Total Per cent.
Ages below 35													
0–	14	8	13	11	10	29	—	9	2	5	5	106	46·7
1–	18	7	9	11	12	11	1	7	8	2	3	89	39·2
2–	8	3	2	2	1	1	—	2	5	—	1	25	11·0
3–	—	1	3	—	—	—	—	1	—	—	—	5	2·2
4–	1	—	—	—	—	—	—	—	—	—	—	1	0·4
5–	—	1	—	—	—	—	—	—	—	—	—	1	0·4
6–	—	—	—	—	—	—	—	—	—	—	—	—	—
7–	—	—	—	—	—	—	—	—	—	—	—	—	—
8–	—	—	—	—	—	—	—	—	—	—	—	—	—
9–	—	—	—	—	—	—	—	—	—	—	—	—	—
10+	—	—	—	—	—	—	—	—	—	—	—	—	—
Total	41	20	27	24	23	41	1	19	15	7	9	227	99·9
Ages 35–39													
0–	16	4	8	11	—	20	6	8	4	2	6	85	23·7
1–	27	10	15	18	7	26	6	11	7	4	3	134	37·4
2–	20	16	8	12	2	15	3	1	5	1	2	85	23·7
3–	6	2	4	4	3	5	—	—	3	1	1	29	8·1
4–	6	2	2	1	2	—	—	—	—	1	—	14	3·9
5–	3	2	—	2	—	—	—	—	—	—	—	7	2·0
6–	—	—	—	—	—	—	—	—	—	—	—	—	—
7–	1	1	—	—	—	—	—	—	—	—	—	2	0·6
8–	—	—	—	—	1	—	—	—	—	—	—	1	0·3
9–	—	—	—	—	—	—	—	—	—	—	—	—	—
10+	—	—	—	—	—	1	—	—	—	—	—	1	0·3
Total	79	37	37	48	15	67	15	20	19	9	12	358	100·0

Ages 40–49														
0–	7	1	6	11	1	15	6	4	9	1	2	63	12·9
1–	31	8	14	31	6	28	3	11	26	8	8	174	35·6
2–	25	12	15	16	2	23	—	6	13	2	12	126	25·8
3–	15	11	7	8	4	7	1	—	4	—	—	57	11·7
4–	13	2	1	4	2	2	—	—	1	—	—	25	5·1
5–	9	3	1	—	—	2	—	—	—	—	—	15	3·1
6–	6	2	1	—	1	—	—	—	1	1	—	12	2·5
7–	7	3	—	—	—	—	—	—	—	—	—	10	2·0
8–	2	—	—	1	—	—	—	—	—	—	—	3	0·6
9–	—	—	—	—	—	—	—	—	—	—	—	—	—
10+	1	1	—	1	—	1	—	—	—	—	—	4	0·8
Total	116	43	45	72	16	78	10	21	54	12	22	489	100·1
Ages 50–59													
0–	8	5	6	13	1	15	—	4	8	5	7	72	18·0
1–	28	8	15	30	3	32	3	5	10	4	8	146	36·6
2–	28	4	9	13	1	9	3	—	4	2	4	77	19·3
3–	16	6	5	5	2	6	2	—	2	3	—	47	11·8
4–	13	6	—	4	1	4	—	1	—	2	—	31	7·8
5–	8	2	1	—	1	2	—	—	1	—	—	15	3·8
6–	1	—	—	—	—	—	—	—	—	—	—	1	0·3
7–	2	1	—	—	—	1	—	—	—	—	—	4	1·0
8–	—	1	—	—	—	—	—	—	—	—	—	1	0·3
9–	—	—	—	—	—	—	—	—	—	—	—	—	—
10+	4	—	—	—	—	1	—	—	—	—	—	5	1·3
Total	108	33	36	65	9	70	8	10	25	16	19	399	100·2

TABLE 1—*continued*

NET INCOMES. ALL AREAS COMBINED—MEN—*continued*

Income £000's	Surgery	Gynae-cology	E.N.T.	Ophthal-mology	Ortho-paedics	Medicine	Psychi-atry	Anaes-thetics	Radio-logy	Derma-tology	Patho-logy	Total	Total Per cent.
Ages 60 and above													
0–	8	—	4	12	1	16	2	3	3	4	2	55	37·4
1–	9	2	2	9	2	8	1	3	4	2	—	42	28·6
2–	7	1	3	8	1	5	1	—	1	1	—	28	19·0
3–	2	1	2	3	—	4	—	—	—	—	—	12	8·2
4–	1	—	—	2	—	2	—	—	—	—	—	5	3·4
5–	2	—	—	—	—	—	—	—	—	—	—	2	1·4
6–	1	—	—	1	—	—	—	—	—	—	—	2	1·4
7–	—	—	—	—	—	—	—	—	—	—	—	—	—
8–	1	—	—	—	—	—	—	—	—	—	—	1	0·7
9–	—	—	—	—	—	—	—	—	—	—	—	—	—
10+	—	—	—	—	—	—	—	—	—	—	—	—	—
Total	31	4	11	35	4	35	4	6	8	7	2	147	100·1
All Ages													
0–	53	18	37	58	13	95	14	28	26	17	22	381	—
1–	113	35	55	99	30	105	14	37	55	20	22	585	—
2–	88	36	37	51	7	53	7	9	28	6	19	341	—
3–	39	21	21	20	9	22	3	1	9	4	1	150	—
4–	34	10	3	11	5	8	—	1	1	3	—	76	—
5–	22	8	2	2	1	4	—	—	1	—	—	40	—
6–	8	2	1	1	1	—	—	—	1	1	—	15	—
7–	10	5	—	—	—	1	—	—	—	—	—	16	—
8–	3	1	—	1	1	—	—	—	—	—	—	6	—
9–	—	—	—	—	—	—	—	—	—	—	—	—	—
10+	5	1	—	1	—	3	—	—	—	—	—	10	—
Total	375	137	156	244	67	291	38	76	121	51	64	1,620	—

The ten net incomes of over £10,000 were : 4 at £10–11, 3 at £11–12, 2 at £14–15 and 1 at £15–16.

TABLE 2

NET INCOMES. LONDON—MEN

Income £000's	Surgery	Gynae-cology	E.N.T.	Ophthal-mology	Ortho-paedics	Medicine	Psychi-atry	Anaes-thetics	Radio-logy	Derma-tology	Patho-logy	Total	Total Per cent.
Ages below 35													
0–	3	3	3	5	3	15	—	7	2	1	1	43	50·6
1–	5	3	2	4	3	3	1	4	4	—	2	31	36·5
2–	2	2	1	2	—	—	—	2	1	—	—	10	11·8
3–	—	—	—	—	—	—	—	1	—	—	—	1	1·2
4–	—	—	—	—	—	—	—	—	—	—	—	—	—
5–	—	—	—	—	—	—	—	—	—	—	—	—	—
6–	—	—	—	—	—	—	—	—	—	—	—	—	—
7–	—	—	—	—	—	—	—	—	—	—	—	—	—
8–	—	—	—	—	—	—	—	—	—	—	—	—	—
9–	—	—	—	—	—	—	—	—	—	—	—	—	—
10+	—	—	—	—	—	—	—	—	—	—	—	—	—
Total	10	8	6	11	6	18	1	14	7	1	3	85	100·1
Ages 35–39													
0–	4	1	1	6	—	14	4	3	2	1	—	36	27·5
1–	11	3	5	6	4	11	1	5	1	1	1	49	37·4
2–	8	4	1	5	1	5	2	1	1	1	1	30	22·9
3–	2	—	1	—	1	3	—	—	—	—	—	7	5·3
4–	—	2	1	1	1	—	—	—	—	—	—	5	3·8
5–	1	—	—	1	—	—	—	—	—	—	—	2	1·5
6–	—	—	—	—	—	—	—	—	—	—	—	—	—
7–	1	1	—	—	—	—	—	—	—	—	—	2	1·5
8–	—	—	—	—	—	—	—	—	—	—	—	—	—
9–	—	—	—	—	—	—	—	—	—	—	—	—	—
10+	—	—	—	—	—	—	—	—	—	—	—	—	—
Total	27	11	9	19	7	33	7	9	4	3	2	131	99·9

TABLE 2—*continued*

NET INCOMES. LONDON—MEN—*continued*

Income £000's	Surgery	Gynae-cology	E.N.T.	Ophthal-mology	Ortho-paedics	Medicine	Psychi-atry	Anaes-thetics	Radio-logy	Derma-tology	Patho-logy	Total	Total Per cent.
Ages 40–49													
0–	3	—	2	1	—	10	2	2	2	1	—	23	13·4
1–	8	2	3	9	1	10	2	7	8	4	3	57	33·1
2–	6	2	4	2	1	9	—	3	3	1	4	35	20·3
3–	4	5	4	2	1	5	1	—	2	—	—	24	14·0
4–	5	—	1	1	1	1	—	—	1	—	—	10	5·8
5–	2	1	—	—	—	2	—	—	—	—	—	5	2·9
6–	2	2	1	—	1	—	—	—	1	—	—	7	4·1
7–	4	1	—	—	—	—	—	—	—	—	—	5	2·9
8–	2	—	—	1	—	—	—	—	—	—	—	3	1·7
9–	—	—	—	—	—	—	—	—	—	—	—	—	—
10+	1	—	—	1	—	1	—	—	—	—	—	3	1·7
Total	37	13	15	17	5	38	5	12	17	6	7	172	99·9
Ages 50–59													
0–	4	1	3	7	—	7	—	2	1	1	3	29	19·9
1–	11	3	6	3	2	12	1	5	2	—	3	48	32·9
2–	9	1	3	2	—	3	3	—	—	—	1	22	15·1
3–	7	3	1	3	—	2	1	—	—	3	—	20	13·7
4–	3	2	—	2	—	2	—	1	—	2	—	12	8·2
5–	4	—	1	—	—	2	—	—	—	—	—	7	4·8
6–	1	—	—	—	—	—	—	—	—	—	—	1	0·7
7–	2	1	—	—	—	1	—	—	—	—	—	4	2·7
8–	—	1	—	—	—	—	—	—	—	—	—	1	0·7
9–	—	—	—	—	—	—	—	—	—	—	—	—	—
10+	1	—	—	—	—	1	—	—	—	—	—	2	1·4
Total	42	12	14	17	2	30	5	8	3	6	7	146	100·1

Ages 60 and above														
0–	...	...	2	—	2	4	—	5	2	1	1	3	—	20	33·9
1–	...	...	5	—	2	3	1	2	—	2	—	—	—	15	25·4
2–	...	...	4	—	2	4	—	1	1	—	—	—	—	12	20·3
3–	...	...	—	1	1	2	—	2	—	—	—	—	—	6	10·2
4–	...	...	1	—	—	—	—	2	—	—	—	—	—	3	5·1
5–	...	...	—	—	—	—	—	—	—	—	—	—	—	—	—
6–	...	...	1	—	—	1	—	—	—	—	—	—	—	2	3·4
7–	...	...	—	—	—	—	—	—	—	—	—	—	—	—	—
8–	...	...	1	—	—	—	—	—	—	—	—	—	—	1	1·7
9–	...	...	—	—	—	—	—	—	—	—	—	—	—	—	—
10+	...	...	—	—	—	—	—	—	—	—	—	—	—	—	—
Total	...	...	14	1	7	14	1	12	3	3	1	3	—	59	100·0
All Ages															
0–	...	...	16	5	11	23	3	51	8	15	8	7	4	151	—
1–	...	...	40	11	18	25	11	38	5	23	15	5	9	200	—
2–	...	...	29	9	11	15	2	18	6	6	5	2	6	109	—
3–	...	...	13	9	7	7	2	12	2	1	2	3	—	58	—
4–	...	...	9	4	2	4	2	5	—	1	1	2	—	30	—
5–	...	...	7	1	1	1	—	4	—	—	—	—	—	14	—
6–	...	...	4	2	1	1	1	—	—	—	1	—	—	10	—
7–	...	...	7	3	—	—	—	1	—	—	—	—	—	11	—
8–	...	...	3	1	—	1	—	—	—	—	—	—	—	5	—
9–	...	...	—	—	—	—	—	—	—	—	—	—	—	—	—
10+	...	...	2	—	—	1	—	2	—	—	—	—	—	5	—
Total	...	...	130	45	51	78	21	131	21	46	32	19	19	593	—

TABLE 3

NET INCOMES. PROVINCES AND SCOTLAND—MEN

Income £000's	Surgery	Gynae-cology	E.N.T.	Ophthal-mology	Ortho-paedics	Medicine	Psychi-atry	Anaes-thetics	Radio-logy	Derma-tology	Patho-logy	Total	Total Per cent.
Ages below 35													
0–	11	5	10	6	7	14	—	2	—	4	4	63	44·4
1–	13	4	7	7	9	8	—	3	4	2	1	58	40·8
2–	6	1	1	—	1	1	—	—	4	—	1	15	10·6
3–	—	1	3	—	—	—	—	—	—	—	—	4	2·8
4–	1	—	—	—	—	—	—	—	—	—	—	1	0·7
5–	—	1	—	—	—	—	—	—	—	—	—	1	0·7
6–	—	—	—	—	—	—	—	—	—	—	—	—	—
7–	—	—	—	—	—	—	—	—	—	—	—	—	—
8–	—	—	—	—	—	—	—	—	—	—	—	—	—
9–	—	—	—	—	—	—	—	—	—	—	—	—	—
10+	—	—	—	—	—	—	—	—	—	—	—	—	—
Total	31	12	21	13	17	23	—	5	8	6	6	142	100·0
Ages 35–39													
0–	12	3	7	5	—	6	2	5	2	1	6	49	21·6
1–	16	7	10	12	3	15	5	6	6	3	2	85	37·4
2–	12	12	7	7	1	10	1	—	4	—	1	55	24·2
3–	4	2	3	4	2	2	—	—	3	1	1	22	9·7
4–	6	—	1	—	1	—	—	—	—	1	—	9	4·0
5–	2	2	—	1	—	—	—	—	—	—	—	5	2·2
6–	—	—	—	—	—	—	—	—	—	—	—	—	—
7–	—	—	—	—	—	—	—	—	—	—	—	—	—
8–	—	—	—	—	1	—	—	—	—	—	—	1	0·4
9–	—	—	—	—	—	—	—	—	—	—	—	—	—
10+	—	—	—	—	—	1	—	—	—	—	—	1	0·4
Total	52	26	28	29	8	34	8	11	15	6	10	227	99·9

Ages 40–49														
0–	4	1	4	10	1	5	4	2	7	—	2	40	12·6
1–	23	6	11	22	5	18	1	4	18	4	5	117	36·9
2–	19	10	11	14	1	14	—	3	10	1	8	91	28·7
3–	11	6	3	6	3	2	—	—	2	—	—	33	10·4
4–	8	2	—	3	1	1	—	—	—	—	—	15	4·7
5–	7	2	1	—	—	—	—	—	—	—	—	10	3·2
6–	4	—	—	—	—	—	—	—	—	1	—	5	1·6
7–	3	2	—	—	—	—	—	—	—	—	—	5	1·6
8–	—	—	—	—	—	—	—	—	—	—	—	—	—
9–	—	—	—	—	—	—	—	—	—	—	—	—	—
10+	—	1	—	—	—	—	—	—	—	—	—	1	0·3
Total	79	30	30	55	11	40	5	9	37	6	15	317	100·0
Ages 50–59														
0–	4	4	3	6	1	8	—	2	7	4	4	43	17·0
1–	17	5	9	27	1	20	2	—	8	4	5	98	38·7
2–	19	3	6	11	1	6	—	—	4	2	3	55	21·7
3–	9	3	4	2	2	4	1	—	2	—	—	27	10·7
4–	10	4	—	2	1	2	—	—	—	—	—	19	7·5
5–	4	2	—	—	1	—	—	—	1	—	—	8	3·2
6–	—	—	—	—	—	—	—	—	—	—	—	—	—
7–	—	—	—	—	—	—	—	—	—	—	—	—	—
8–	—	—	—	—	—	—	—	—	—	—	—	—	—
9–	—	—	—	—	—	—	—	—	—	—	—	—	—
10+	3	—	—	—	—	—	—	—	—	—	—	3	1·2
Total	66	21	22	48	7	40	3	2	22	10	12	253	100·0

TABLE 3—*continued*

NET INCOMES. PROVINCES AND SCOTLAND—MEN—*continued*

Income £000's	Surgery	Gynae-cology	E.N.T.	Ophthal-mology	Ortho-paedics	Medicine	Psychi-atry	Anaes-thetics	Radio-logy	Derma-tology	Patho-logy	Total	Total Per cent.
Ages 60 and above													
0–	6	—	2	8	1	11	—	2	2	1	2	35	39·8
1–	4	2	—	6	1	6	1	1	4	2	—	27	30·7
2–	3	1	1	4	1	4	—	—	1	1	—	16	18·2
3–	2	—	1	1	—	2	—	—	—	—	—	6	6·8
4–	—	—	—	2	—	—	—	—	—	—	—	2	2·3
5–	2	—	—	—	—	—	—	—	—	—	—	2	2·3
6–	—	—	—	—	—	—	—	—	—	—	—	—	—
7–	—	—	—	—	—	—	—	—	—	—	—	—	—
8–	—	—	—	—	—	—	—	—	—	—	—	—	—
9–	—	—	—	—	—	—	—	—	—	—	—	—	—
10+	—	—	—	—	—	—	—	—	—	—	—	—	—
Total	17	3	4	21	3	23	1	3	7	4	2	88	100·1
All Ages													
0–	37	13	26	35	10	44	6	13	18	10	18	230	—
1–	73	24	37	74	19	67	9	14	40	15	13	385	—
2–	59	27	26	36	5	35	1	3	23	4	13	232	—
3–	26	12	14	13	7	10	1	—	7	1	1	92	—
4–	25	6	1	7	3	3	—	—	—	1	—	46	—
5–	15	7	1	1	1	—	—	—	1	—	—	26	—
6–	4	—	—	—	—	—	—	—	—	1	—	5	—
7–	3	2	—	—	—	—	—	—	—	—	—	5	—
8–	—	—	—	—	1	—	—	—	—	—	—	1	—
9–	—	—	—	—	—	—	—	—	—	—	—	—	—
10+	3	1	—	—	—	1	—	—	—	—	—	5	—
Total	245	92	105	166	46	160	17	30	89	32	45	1,027	—

TABLE 4

NET INCOMES. ALL AREAS COMBINED—MEN

Percentage Distribution for Different Specialties

Net Income	Surgery						Medicine						Gynaecology						Ear, Nose and Throat						Ophthalmology						All Others					
	Ages						Ages						Ages						Ages						Ages						Ages					
	Under 35	35–	40–	45–	50–	55–59	Under 35	35–	40–	45–	50–	55–59	Under 35	35–	40–	45–	50–	55–59	Under 35	35–	40–	45–	50–	55–59	Under 35	35–	40–	45–	50–	55–59	Under 35	35–	40–	45–	50–	55–59
£ 0–	22·0	6·3	3·8	1·6	5·0	—	39·0	13·4	7·5	5·3	2·8	5·9	20·0	—	4·8	—	5·3	—	14·8	5·4	4·2	4·8	3·8	10·0	12·5	—	2·4	—	—	5·6	12·2	7·8	4·5	—	3·9	13·9
500–	12·2	13·9	1·9	4·7	6·7	2·1	31·7	16·4	17·5	7·9	8·3	26·5	20·0	10·8	—	—	5·3	21·4	33·3	16·2	8·3	9·5	7·7	20·0	33·3	22·9	14·3	13·3	20·7	13·9	29·7	21·1	10·4	19·1	13·7	30·6
1,000–	24·4	15·2	7·7	12·5	11·7	12·5	19·5	17·9	25·0	21·1	27·8	14·7	25·0	16·2	4·8	4·5	—	—	25·9	18·9	25·0	19·0	23·1	40·0	29·2	25·0	21·4	13·3	34·5	25·0	27·0	23·3	19·4	23·5	23·5	19·4
1,500–	19·5	19·0	17·3	15·6	11·7	16·7	7·3	20·9	10·0	15·8	22·2	26·5	10·0	10·8	14·3	13·6	15·8	35·7	7·4	21·6	8·3	9·5	15·4	10·0	16·7	12·5	21·4	30·0	6·9	25·0	17·6	18·9	26·9	22·1	17·6	13·9
2,000–	9·8	10·1	11·5	12·5	13·3	12·5	2·4	10·4	15·0	15·8	5·6	8·8	15·0	27·0	19·0	4·5	5·3	7·1	3·7	13·5	25·0	19·0	15·4	10·0	4·2	10·4	11·9	6·7	13·8	11·1	5·4	6·7	20·9	16·2	11·8	13·9
2,500–	9·8	15·2	13·5	6·3	8·3	18·7	—	11·9	10·0	18·4	2·8	8·8	—	16·2	23·8	9·1	—	14·3	3·7	8·1	8·3	14·2	11·5	10·0	4·2	14·6	11·9	13·3	6·9	8·3	6·8	8·9	6·0	8·8	3·9	2·8
3,000–	—	5·1	5·8	9·4	10·0	—	—	6·0	10·0	2·6	13·9	2·9	5·0	2·7	9·5	27·3	15·8	14·3	11·1	8·1	—	19·0	11·5	—	—	6·2	9·5	3·3	6·9	5·6	1·4	3·3	7·5	2·9	7·8	2·8
3,500–	—	2·5	5·8	4·7	10·0	8·3	—	1·5	2·5	2·6	—	—	—	2·7	9·5	4·5	5·3	—	—	2·7	12·5	—	7·7	—	—	2·1	2·4	3·3	—	2·8	—	5·6	1·5	1·5	5·9	2·8
4,000+	2·4	12·7	32·7	32·8	23·3	29·2	—	1·5	2·5	10·5	16·7	5·9	5·0	13·5	14·3	36·4	47·4	7·1	—	5·4	8·3	4·8	3·8	—	—	6·2	4·8	16·7	10·3	2·8	—	4·4	3·0	5·9	11·8	—
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
No. of Men ...	41	79	52	64	60	48	41	67	40	38	36	34	20	37	21	22	19	14	27	37	24	21	26	10	24	48	42	30	29	36	74	90	67	68	51	36
Mean Income	£ 1,399	£ 2,188	£ 3,381	£ 3,341	£ 2,916	£ 3,465	£ 773	£ 1,721	£ 1,758	£ 2,355	£ 2,275	£ 1,877	£ 1,465	£ 2,431	£ 3,045	£ 4,082	£ 3,776	£ 2,114	£ 1,283	£ 1,874	£ 2,246	£ 2,231	£ 2,189	£ 1,380	£ 1,167	£ 1,913	£ 2,195	£ 2,403	£ 1,916	£ 1,708	£ 1,242	£ 1,770	£ 1,868	£ 1,900	£ 2,154	£ 1,378
Median Income	1,350	1,950	2,750	2,800	2,650	2,650	650	1,550	1,500	2,000	1,850	1,550	1,200	2,150	2,650	3,300	3,550	1,850	1,100	1,650	2,200	2,250	2,000	1,300	1,050	1,700	1,800	1,900	1,450	1,600	1,050	1,450	1,750	1,650	1,750	1,200

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TABLE 5

NET INCOMES. ALL AREAS COMBINED—MEN

Surgery, Medicine and Gynaecology combined

Percentage Distribution

Net Income	Ages					
	Under 35	35–	40–	45–	50–	55–59
£						
0–	28·4	7·7	5·3	2·4	4·3	2·1
500–	21·6	14·2	7·1	4·8	7·0	13·5
1,000–	22·5	16·4	13·3	13·7	14·8	11·5
1,500–	12·7	18·0	14·2	15·3	15·7	22·9
2,000–	7·8	13·7	14·2	12·1	9·6	10·4
2,500–	3·9	14·2	14·2	10·5	5·2	14·6
3,000–	1·0	4·9	8·0	10·5	12·2	3·1
3,500–	—	2·2	5·3	4·0	6·1	4·2
4,000+	2·0	8·7	18·6	26·6	25·2	17·7
Total	100	100	100	100	100	100
No. of men ...	102	183	113	124	115	96
Mean Income ...	£ 1,160	£ 2,066	£ 2,744	£ 3,170	£ 2,858	£ 2,705
Lower quartile ...	450	1,150	1,450	1,650	1,450	1,450
Median Income ...	1,000	1,750	2,350	2,550	2,450	2,000
Upper quartile ...	1,650	2,650	3,350	4,050	3,950	3,250

TABLE 6

NET INCOMES. ALL AREAS AND ALL SPECIALTIES COMBINED—MEN

Percentage Distribution

Net Income	Ages								All ages combined
	Under 35	35–	40–	45–	50–	55–	60+	40–54	
£									
0–	19·8	6·4	4·5	1·6	3·6	5·6	17·0	3·2	7·8
500–	26·9	17·3	9·3	10·3	10·4	17·4	20·4	10·0	15·7
1,000–	25·1	19·6	17·5	16·9	20·4	17·4	16·3	18·2	19·2
1,500–	14·1	17·9	18·3	18·5	14·9	20·8	12·2	17·3	16·9
2,000–	6·2	11·5	16·7	13·2	11·3	11·2	10·9	13·8	11·7
2,500–	4·8	12·3	11·0	10·7	5·9	10·7	8·2	9·3	9·4
3,000–	2·2	5·0	7·3	8·2	10·4	3·4	3·4	8·6	5·9
3,500–	—	3·1	4·5	3·3	5·4	3·4	4·8	4·4	3·4
4,000+	0·9	7·0	11·0	17·3	17·6	10·1	6·8	15·2	10·1
Total ...	100	100	100	100	100	100	100	100	100
No. of men ...	227	358	246	243	221	178	147	710	1,620
Mean Income ...	£ 1,202	£ 1,951	£ 2,363	£ 2,638	£ 2,492	£ 2,160	£ 1,739	£ 2,498	£ 2,090
Lower quartile...	550	1,050	1,350	1,450	1,250	1,050	750	1,350	1,050
Median Income	1,050	1,650	2,050	2,150	2,050	1,750	1,450	2,050	1,750
Upper quartile...	1,650	2,550	2,850	3,150	3,350	2,550	2,350	3,150	2,650

TABLE 7

FEMALES—NET INCOME. ALL AREAS AND ALL SPECIALTIES COMBINED

Income £000's	Absolute Nos. at Ages					
	Under 35	35–39	40–49	50–59	60+	Total
0–	7	16	22	6	2	52
1–	—	3	10	2	1	16
2–	—	1	2	—	—	3
3–	—	—	1	1	—	2
4–	—	—	—	—	—	—
5–	—	—	—	—	—	—
6–	—	—	—	—	—	—
7–	—	—	—	—	—	—
8–	—	—	—	—	—	—
9–	—	—	—	—	—	—
10+	—	—	—	—	—	—
Total ...	7	20	35	9	3	74

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